AFFORDABLE CARE ACT
MASSACHUSETTS IMPLEMENTATION UPDATE

September 5, 2012

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MA-ACA Website

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These Updates, published by the Executive Office of Health and Human Services (EOHHS) in consultation with the other state agencies involved in ACA implementation, will bring you news related to the implementation of provisions of the ACA here in Massachusetts.

Grants and Demonstrations

The ACA provides funding opportunities to transform how health care is delivered, expand access to care and support healthcare workforce training.

Grant Activity

August 31, 2012 The Executive Office of Health and Human Services submitted an application to CMS for an Adult Medicaid Quality Grants: Measuring and Improving the Quality of Care in Medicaid grant under §2701 of the ACA. Funding is available to support states in developing their capacity for standardized collection and reporting of data on the quality of health care provided to adults covered by Medicaid. This funding opportunity will focus on the Initial Core Set of Measures published in the Federal Register Notice on January 4, 2012.

Under this funding opportunity, MassHealth proposes to accomplish the following aims: 1) Implement measures from the Adult Initial Core Set Measures in
both years of the grant; 2) Prepare and implement a strategy for enhancing MassHealth's capacity to prepare, interpret, report and use quality measure information; and 3) Use data to drive decision-making and quality improvement. These goals will be implemented through a partnership of MassHealth, the University of Massachusetts Medical School, the Department of Public Health and the Division of Healthcare Finance and Policy (soon to be named the Center for Health Information and Analysis as authorized by Massachusetts' Chapter 224 of the Acts of 2012).

The project narrative can be viewed on our website under the Grants and Demonstrations

section at: Narrative

August 22, 2012 The Centers for Disease Control and Prevention (CDC) awarded $2,758,115 to DPH for a Building and Strengthening Epidemiology and Laboratory Capacity (ELC) grant under §4002 and 4304 of the ACA.

The Epidemiology and Laboratory Capacity for Infectious Diseases Cooperative Agreement (ELC) grant plays a critical role in strengthening national infectious disease infrastructure by providing funding to state health departments to prevent, detect, and respond to new and emerging infectious diseases. With ELC support, the Massachusetts Public Health Department will build its public health capacity by hiring and training staff, buying laboratory equipment and supplies for diagnosing emerging pathogens, and investing in information technology to improve disease reporting and monitoring.

The project narrative can be viewed on our website under the Grants and Demonstrations section at: Narrative

Guidance

8/31/12 IRS/Treasury issued Notice 2012-58, Determining Full-Time Employees for Purposes of Shared Responsibility for Employers Regarding Health Coverage (§ 4980H). The notice addresses questions for employers under the shared responsibility provisions as authorized by §1513 of the ACA.

The notice includes a suggested definition about who counts as a full-time employee and offers an explanation of safe harbors. According to the notice, the question of how full-time employment status is to be determined impacts whether an employer owes a tax penalty for failing to provide adequate or affordable health insurance to full-time employees who consequently receive premium tax credits. Beginning in 2014, employers with 50 or more full-time employees that do not offer affordable health coverage to their full-time employees may be required to make a shared responsibility payment. The notice also says that employers could rely on W-2 forms to determine whether an offer of insurance meets the ACA's affordability definition. Specifically, Notice 2012-58 continues the IRS policy that states that, regardless of an employee's actual household income, an employer is exempt from paying a penalty if the employee's contribution for premiums does not exceed 9.5% of the employee's W-2 wages.

Comments are due September 30, 2012.

Read Notice 2012-58 at: http://www.irs.gov/pub/irs-drop/n-12-58.pdf

8/31/12 HHS, Labor and Treasury issued Notice 2012-59, Guidance on 90-Day Waiting Period Limitation under Public Health Service Act § 2708. The document addresses the question of how the 90-day waiting period limit for employment-based health insurance enacted by §1201 of the ACA would be applied. Specifically, the guidance states that group plans can't apply waiting periods of more than 90 days starting in 2014.

The ACA defines how to apply both the employer penalty and waiting period for employees hired on a full-time basis. Under the ACA, an employer that offers health insurance must cover a new full-time employee no later than 90 days after employment. A large employer (with more than 50 full-time-equivalent employees) must offer adequate and affordable coverage to employees hired as full-time employees or risk owing a tax penalty if an employee goes to the exchange to obtain a premium tax credit. Full-time employment is defined as 30 hours a week

(or 130 hours a month), but many employees work 20 hours one week and 45 hours the next, or may work 40 hours a week but only for two months a year during the growing or holiday seasons. The notice provides examples as to how employers should handle employees who work variable hours and seasonal employees.

Comments are due September 30, 2012.

Read the guidance at: http://cciio.cms.gov/resources/files/Files2/2708-guidance-8-31-2012.pdf

8/31/12 CMS published an ACA-related Medicare final rule called "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates; Hospitals' Resident Caps for Graduate Medical Education Payment Purposes; Quality Reporting Requirements for Specific Providers and for Ambulatory Surgical Centers." The final rule implements portions of the following sections: 3001, 3005, 3008, 3011, 3014, 3021, 3025, 3106, 3123, 3124, 3125, 3137, 3141, 3401, 5503, 5506, 10302, 10309, 10312, 10313, 10314, 10319, 10322 and 10324.

The rule revises the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs of acute care hospitals. The changes are generally applicable to discharges occurring on or after October 1, 2012. The rule also updates the rate-of-increase limits for certain hospitals excluded from the IPPS that are paid on a reasonable cost basis subject to these limits. The updated rate-of-increase limits will be effective for cost reporting periods beginning on or after October 1, 2012.

The rule updates the payment policies and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs). Generally, the changes will be applicable to discharges occurring on or after October 1, 2012. In addition, the rule implements changes relating to determining a hospital's full-time equivalent (FTE) resident cap for the purpose of graduate medical education (GME) and indirect medical education (IME) payments. The rule establishes new requirements or revised requirements for quality reporting by specific providers (acute care hospitals, PPS-exempt cancer hospitals, LTCHs, and inpatient psychiatric facilities (IPFs)) that are participating in Medicare. The rule also establishes requirements for the Hospital Value-Based Purchasing (VBP) Program and the Hospital Readmissions Reduction Program.

Read the rule (which was published in the Federal Register on August 31, 2012) at: http://www.gpo.gov/fdsys/pkg/FR-2012-08-31/pdf/2012-19079.pdf

Read the press release at: Press Release

8/30/12 CMS published an amendment to interim final rule with request for comments regarding the Pre-Existing Condition Insurance Plan (PCIP) Program under §1101 of the ACA. The amendment limits eligibility for the PCIP by making the definition of "lawfully present" consistent with recent changes in the Department of Homeland Security's (DHP) immigration policy. The policy prevents certain young immigrants who have been exempted from deportation under a recent DHP change from enrolling in the PCIP.

The amended rule explains that these particular individuals will also be excluded from subsidized coverage in the Affordable Insurance Exchanges and from receiving premium tax credits because the eligibility definitions under the PCIP rules also govern the Exchanges. For more information on the affected individuals, read the interim final rule, linked below.

The PCIP program is a temporary federal program designed to cover uninsured Americans with pre-existing conditions until 2014. In 2014, individuals will be able to purchase health insurance

through the Exchange where they cannot be denied coverage because of a pre-existing condition. The interim final rule on the PCIP was published in the Federal Register on July 30, 2010.

Massachusetts is a guarantee-issue state where existing commercial plans already offer guaranteed coverage at premiums comparable to PCIP so the need for such a program may not be as high as in other states. As a result, the rules for the federally-administered PCIP program in Massachusetts vary from non guarantee-issue states. United States citizens and nationals who have been without health insurance for at least six months can qualify for PCIP coverage in Massachusetts if they can provide a letter from a doctor, physician assistant, or nurse practitioner dated within the past 12 months stating that they have or, at any time in the past, had a medical condition, disability, or illness. Applicants do not need to provide a denial letter from an insurance company, one of the requirements for PCIP enrollment in non guarantee-issue states. This may provide an additional opportunity for coverage for individuals with pre-existing conditions in the state who might have to wait up to eleven months to enroll in other plans in the state due to eligibility or open enrollment restrictions under Massachusetts law.

According to HHS, as of May 2012, the PCIP provided insurance to over 61,000 people with high-risk pre-existing conditions nationwide. In Massachusetts, there are 14 residents who are enrolled in this program.

To learn more about the program rules In Massachusetts, visit:
http://www.hhs.gov/news/press/2011pres/05/20110531b.html

For more information on the PCIP program, including how to apply, visit:
http://www.healthcare.gov/law/features/choices/pre-existing-condition-insurance-plan/#moreinf

Comments on the amended final Pre-Existing Condition Insurance Plan Program rule are due October 29, 2012.

Read the amended interim final Pre-Existing Condition Insurance Plan Program rule at:
http://www.gpo.gov/fdsys/pkg/FR-2012-08-30/pdf/2012-21519.pdf

8/24/12 HHS issued a final rule, Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements; and a Change to the Compliance Date for the International Classification of Diseases, 10th Edition (ICD-10-CM and ICD-10-PCS) Medical Data Code Sets. The final rule implements portions of §1104 of the ACA which requires the adoption of a standard national unique health plan identifier (HPID).HHS projects that the net savings of implementing HPID for the health care industry is between $1.3 billion and $6 billion over ten years.

The rule also adopts the use of and establishes requirements for the implementation of HPID. Furthermore, the final rule implements another data element, other entity identifier (OEID), for entities that are not health plans, health care providers, or individuals but need to be identified in standard transactions. The rule also specifies when an organization must require certain non-covered individual health care providers who are prescribers to obtain and disclose a National Provider Identifier (NPI).

The final rule also finalizes a one-year proposed delay and changes the compliance date to October 1, 2014 for use of new diagnosis codes that classify diseases and health problems. These code sets, known as the International Classification of Diseases, 10th Edition diagnosis and procedure codes, or ICD-10, will include codes for new procedures and diagnoses that

improve the quality of information available for quality improvement and payment purposes.

This regulation is the fourth in a series issued by HHS aimed at streamlining health care administrative transactions and maximizing the use of existing standards by providers. **HHS published the first regulation**, Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions on July 8, 2011. The regulation established new operating rules for electronic health care transactions in order to simplify existing requirements for use by health plans and providers in determining a patient's health insurance eligibility and the status of a health care claim submitted to a health insurer. On January 10, 2012, **HHS published a second regulation**, Administrative Simplification: the Adoption of Standards for Health Care Electronic Funds Transfers and Remittance Advice, which adopts standards for health care claim payments made via EFT and for ERA. On August 10, 2012, **HHS published a third regulation,** Administrative Simplification: Adoption of Operating Rules for Health Care Electronic Funds Transfers (EFT) and Remittance Advice Transactions, which requires the adoption of operating rules for making health care claim payments electronically and describing adjustments to claim payments.

Read the final rule, **Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements; and a Change to the Compliance Date for the International Classification of Diseases, 10th Edition (ICD-10-CM and ICD-10-PCS) Medical Data Code Sets** (which was published on September 5, 2012) at: http://www.gpo.gov/fdsys/pkg/FR-2012-09-05/pdf/2012-21238.pdf

Read the press release at: http://www.hhs.gov/news/press/2012pres/08/20120824e.html

Read the fact sheet at: CMS

Prior guidance can be viewed at www.healthcare.gov

News

8/31/12 CMS announced that two new Consumer Oriented and Operated Plan (CO-OP) repayable loans will be awarded, including one servicing Massachusetts, to non-profit entities to help establish private non-profit, consumer-governed health insurance companies that offer qualified health plans in the health insurance exchanges. Established under §1322 of the ACA, the goal of CO-OP program is to create a new CO-OP in every state in order to expand the number of exchange health plans with a focus on integrated care and plan accountability.

One non-profit receiving a loan is: **Minutemen Health, Inc. (MHI),** a CO-OP that received an $88,498,080 loan to deliver efficient, quality healthcare financing to future membership in Massachusetts. MHI is sponsored by both Tufts Medical Center and Vanguard Health Systems and both organizations plan to participate in the MHI network. According to their proposal, MHI will initially provide regional coverage in eastern and central Massachusetts. By July 2014, MHI will offer coverage throughout the state.

Another non-profit receiving a loan is: **Community Health Alliance Mutual Insurance Company (CHA),** a CO-OP that received a $73,306,700 loan to create new health insurance options in Tennessee to meet the medical, wellness, and financial needs of consumers. CHA will offer its insurance plans throughout the state.

Starting in 2014, CO-OPs will be able to offer plans both inside and outside of health insurance exchanges and will operate in 20 states, including: Massachusetts, Tennessee, Colorado, Utah,

Kentucky, Vermont, Arizona, Connecticut, Michigan, Nevada, Maine, South Carolina, Oregon, New Mexico, Montana, Iowa, Nebraska, Wisconsin, New Jersey, and New York. CMS awarded the first round of CO-OP loans on February 21, 2012. To date, a total $1,560,856,720 has been awarded. CMS will continue to review applications on a quarterly schedule through December 31, 2012 and announce additional awardees on a rolling basis. According to CMS, CO-OP loans are only made to private, nonprofit entities that demonstrate a high probability of financial viability.

For more information, including a list of previous CO-OP loans awarded, visit: http://www.healthcare.gov/news/factsheets/2012/02/coops02212012a.html

8/29/12 HHS announced that $23 million has been distributed to 37 Public Health Training Centers to help strengthen the public health workforce and fight disease and illness. The funding, authorized under Title V of the ACA, provides training to current and future public health workers on key public health issues. In addition, funds will be used to enhance basic public health skills. Two universities in Massachusetts were awarded grants; University of Massachusetts, Amherst received $619,671 and the Trustees of Boston University, Boston University Medical Campus received $649,993.

Read the press release at: http://www.hhs.gov/news/press/2012pres/08/20120829a.html

A full list of awards is available at: http://www.hrsa.gov/about/news/2012tables/120829publichealthtraining.html

8/29/12 The Patient-Centered Outcomes Research Institute, known as PCORI, announced that it will host three workshops later this year to gather feedback from patients and other stakeholders on its process for choosing research issues and developing future funding announcements. Created under §6301 of the ACA, PCORI is an independent nonprofit, expected to provide billions in federal funds for studies, and tasked with conducting patient-centered outcomes research.

The workshops will be held in Washington, D.C. in October and December 2012.

For more information on PCORI, including how to register for the workshops, visit: http://www.pcori.org/workshops/

On July 23, 2012 PCORI announced that it is accepting comments on its draft Methodology Report, which proposes standards for the conduct of patient-centered outcomes research. The report explores best practices for comparative effectiveness research and is intended to guide researchers as they formulate questions and determine the best methods to use in producing a PCORI-funded study. Comments can be submitted though an online comment and survey tool where respondents may answer a series of general and specific questions about the report. A PCORI committee will review the comments and revise the draft for finalization by PCORI's Board of Governors in November, 2012. The report will also be revised as new research methods are implemented and verified, to ensure it remains the basis for reliable patient-centered outcomes research. Comments on the draft Methodology Report are due September 14, 2012.

In May 2012 PCORI issued its first funding announcement. PCORI Funding Announcements are issued to support comparative clinical effectiveness research that will provide patients with the ability to make better-informed health care decisions and that is based on PCORI's National Priorities for Research and Research Agenda.

For more on funding announcements, visit:
http://www.pcori.org/funding-opportunities/funding-announcements/

According to PCORI, applicants will be required to adhere to the standards in the finalized Methodology Report in future funding cycles.

Upcoming Events

Quarterly Affordable Care Act Implementation Stakeholder Meeting
Wednesday, September 19, 2012, 1:00 PM- 2:00 PM
1 Ashburton Place, 21st Floor
Boston, MA

Bookmark the **Massachusetts National Health Care Reform website** at: http://mass.gov/national health reform to read updates on ACA implementation in Massachusetts.

Remember to check http://mass.gov/masshealth/duals for information on the **"Integrating Medicare and Medicaid for Dual Eligible Individuals"** initiative.